The Wisconsin Partnership Program

(Summary by Brenda Schmitthenner)

The Department of Health and Family Services contracted with community-based organizations to implement the Wisconsin Partnership Program. These organizations then subcontracted with hospitals, clinics, HMOs, and other providers to ensure a comprehensive network of acute and LTC services. The program began serving participants in January 1996.

The Wisconsin Partnership Program is an integrated program of health and LTC designed to improve access and quality while achieving cost savings. Acute and LTC services are coordinated across settings (called points of intersection) using an ID team consisting of a physician, RN, nurse practitioner and SW or independent living coordinator. The nurse practitioner bridges the gap between medical and social services and integrates previously fragmented services. Medicaid and Medicare funding are combined to avoid fragmentation and duplication of services and to reduce costs. A capitation system is used to achieve the cost savings and flexibility that are typically found in managed care programs.

Consumer choice is the cornerstone of this program. Individuals enrolled in the program are offered a choice of care, choice of setting, and choice of the manner in which service is delivered. They may choose their primary physician within very broad parameters. Participants must be Medicaid eligible or dually eligible and meet the care requirements for a SNF. Participation in the program is voluntary and participants may disenroll at any time. Contractors may not disenroll participants except under stringent

protocols that have been approved by the Wisconsin Dept. of Health and Family Services.

The primary objectives of this program are: control health costs among elderly and physically disabled who meet SNF criteria, increase quality through the integration of preventive, primary and chronic care via the ID team model, improve health outcomes through the delivery of integrated care, increase the role of the participant in decision-making, increase quality through the development and use of consumer-defined measures of quality, and demonstrate that community based organizations can provide a comprehensive range of LTC support and acute health care to a SNF level population of elderly and people with disabilities.

The program planned to control costs by capitating Medicare and Medicaid funding through a managed care system. This capitation prevents cost shifting and will provide an incentive to provide preventive care. The comprehensive range of services provided by the program further reduces any incentive to shift costs. Data collected during the demonstration project will be used to develop improved risk adjusters for special populations, enabling more valid and reliable cost estimates.

The ID team ensures that care is coordinated across systems that currently operate in parallel. The team coordinates all aspects of care and focuses on the points of intersection. They coordinate transitions between service providers. The ID team is knowledgeable about all aspects of the participant's care, preventing the prescribing of duplicative or contradictory treatments. The participant's involvement in the team and decision-making ensures a high degree of customer satisfaction. Switching the focus to preventive services reduces unnecessary hospital and SNF care and results in improved

health outcomes for participants. The importance for the ID team to make cost-effective decisions is emphasized. The responsibility for making cost-effective decisions is shifted in this model from an impersonal administrative organization to the team that is responsible for both quality of care and cost management. Participants are educated about their role regarding choices in the context of a managed care system. Participants also receive health education as a means of preventive care.

Because participants can disenroll with relative ease, the program must provide a high quality service package that fosters the customer satisfaction necessary to retain enrolled participants. By ensuring that participants' choices are upheld, customer satisfaction is fostered and enrollees remain in the program.

The infastructure developed by the Wisconsin Partnership Program assists community-based organizations in developing their capacity to meet the financial and organizational requirements to provide acute health as well as community-based LTC support in a managed care, risk-based environment.

In December 1995, Elder Care of Dane County became the first agency to begin enrolling members into the Partnership Program. Elder Care had been a community-based provider of LTC services since 1976. Elder Care had been a PACE site providing integrated services since January 1995. Elder Care has served 335 members over the past five years. Each ID team consists of a nurse practitioner, two RNs, and one social service coordinator. They have six ID teams currently in place. Elder Care's network for acute and primary care is comprised of four hospitals, 32 clinics, and five physician group practices. The majority of Elder Care's members live in the community with 86% living in private homes, 2% living in SNFs and 13 % living in Board and Care facilities. The

Elder Care staff developed and implemented a process for retrospective review of admissions and emergency room visits, using a standard data collection form. Staff evaluates the appropriateness of care preceding and concurrent with these events and maintain records of their findings. These records are tracked by the quality committee to monitor for trends and identify opportunities for specific quality improvement activities.

The second elderly provider site is the Community Care Organization (CCE) located in Milwaukee. This was the first agency in Wisconsin to provide an integrated model of community-based, managed LTC for adults through the PACE program. The ID teams are physically located in centralized locations where member enrollment is the heaviest. Two of CCE's ID teams are physically located at elderly-only housing units and one team is located in a hospital where CCE has developed a dementia adult daycare program. Partnership services are also taken out to members not living in these congregate housing situations but who are in the immediate geographical area. This model works well in a large urban area.

CCE began enrolling members in 1996 and on December 31, 1999, 162 members were enrolled. Of those enrolled, 151 members live in the community, two live in SNFs and nine live in Board and Care homes. There is greater net growth in enrollment at this site than any other. CCE works with seven area clinics and three major hospital networks in the Milwaukee area. Twenty-eight physicians involved in the Partnership provide primary care services to members and over 200 specialists are available to serve members. The use of community care physicians to provide primary care is a significant departure from the PACE model. CCE believes that this model works well because it utilizes an experienced nurse practitioner to accomplish the frequent monitoring and

intervention of multiple chronic diseases in the population. The CCE model continues to rely on the infastructure that was developed by PACE.

CCE works with four ID teams. Each team serves a geographical area. The size and make-up of each team depends on the area served. CCE reports that the service delivery model utilizing increased in-home services and a reduced interdisciplinary model of care has been effective in providing care to members. It should be noted, however, that there has been higher utilization of pharmacy and inpatient hospitalizations for members within the past year.

The Community Health Partnership (CHP) is the first "replication" site for the Partnership Program. CHP is the only agency to provide serves to both the elderly and the disabled populations. This model serves members in a three county area. CHP began enrolling members in May. 1997. Their total enrollment was 183 members by the end of December 1999. CHP is located in a rural area and covers a geographic area of three counties. It has 148 health and LTC providers in its network and has been able to develop a collaborative relationship with home health agencies in the area.

CHP's case management is provided by five ID teams. Each team is comprised of a nurse practitioner, RN, social services coordinator and team assistant. CHP also employs 120 daily living assistants available to serve members.

The final site for the demonstration project is the Community Living Alliance (CLA). This small community-based non-profit organization in Madison serves adults with significant physical disabilities that reside in Dane County. CLA was selected as a Partnership site in 1994 and began enrolling members in May 1996. Enrollment has not grown rapidly, but by the end of December 1999, CLA had 140 members. At least 42 %

of CLA's members have been diagnosed with mental and/or substance abuse problems. The majority of CLA members also have chronic health conditions. Many are non-compliant with the treatment plan. The participants that are enrolled have significantly more complex medical and social issues than were anticipated. This complex population required CLA to develop the infastructure needed to operate a program with more expertise in acute and primary health care than originally expected. CLA works with 19 clinics, three hospitals, and two health systems in Dane County. CLA's provider network also includes DME providers, chiropractors, pharmacies, adult day care providers and nursing homes.

CLA has seven ID teams in place to serve members and employs a total of 146 personal living assistants. Each team is comprised of a nurse practitioner, an RN and a social service coordinator. Members can choose from 34 primary care physicians. The role of the nurse practitioner is to form a collaborative practice arrangement with the physician, which relieves the physician of some of the more routine care provided to members and, also, augments the primary care that the physician provides. During the past three years, CLA has seen improved clinical and functional outcomes for their members. At the end of 1999, 94% of CLA members were living outside of an institutional setting. Initial reports indicate an increase in ER visits and hospitalizations over the past year but given the medical and social complexity of the members, this shouldn't be surprising.

The Wisconsin Partnership Program is a huge success and demonstrates that integrating acute and LTC care is feasible, can be implemented by community-based organizations, and works for multiple age and target groups in various geographic

settings, urban and rural. To reduce service fragmentation, the Wisconsin Partnership Program has been developed as a fully integrated managed LTC program. A unified stream eliminates conflicting incentives-providers are selected and coordinated by a single payer agency. A unified ID team works with the member through all situations and settings. Care is holistic and cohesive goals are integrated into a single plan. In many respects, the Partnership Program resembles PACE. The differences are: the Partnership allows members to maintain the relationship they have already established with their doctor and services are primarily home-based and do not rely on a day center as a structure in which to provide services. This demonstration project has shown that an integrated management model does result in more consumer-centered. LTC.

The Partnership has begun to collect data with the intent of establishing performance benchmarks for community based LTC. Very little is known about what constitutes good performance in health or LTC for frail populations.

The Partnership organizations recognized the need to purchase or develop an IT system for this project. This system would need to facilitate case management and serve as a medical record and also capture data to create utilization reports. The IT system has evolved and is currently being tested. The release of the final IT system is scheduled for November 2000. Member organizations have also pooled their resources to provide stop-loss protection. In addition to the development of the IT system, claims processing and clinical protocol systems are also being developed.

It has been difficult for the Partnership organizations to obtain appropriate information about level of care placement needs for members. Currently a tool is being developed and tested that will hopefully deliver more consistent level of care

determinations across settings. The cost effectiveness of the Partnership Program is dependent upon each team carrying a "full" caseload. It is apparent that a tool to assess member complexity and acuity to predict workload is needed.

The most difficult requirement to meet by this program has been budget neutrality. It has proven to be quite a challenge for this program. Wisconsin is confident that the Partnership program will prove itself to be budget neutral in 1999. The budget neutral cap for 1999 was $3,005. The average capitation paid to the Partnership sites was only $2,513 in 1999. There was no information available about how the capitation rate was calculated.

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